California State Board of Pharmacy
400 R Street, Suite 4070, Sacramento, CA 95814
Phone (916) 445-5014
Fax (916) 327-6308

STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GRAY DAVIS, GOVERNOR

DEPARTMENT OF CONSUMER AFFAIRS
BOARD OF PHARMACY
NORTHERN COMPLIANCE COMMITTEE MEETING
MINUTES

DATE:	May 2, 2000
TIME:	10:15 a.m. – 12:35 p.m.
LOCATION:	400 R Street Suite 3020 Sacramento, CA 95814
BOARD MEMBER PRESENT:	Rich Mazzoni, Chairperson Marilyn Shreve, Board Member Donald Gubbins, Board Member
STAFF PRESENT:	Robert Ratcliff, Supervising Inspector Brenda Barnard, Pharmacy Inspector Lin Hokana, Pharmacy Inspector LaVonne Powell, Staff Counsel Linda Kapovich, Enforcement Technician
ALSO PRESENT:	Tom Lee, RPH, PIC Florliza Agramon, RPH Ronda Lowe, Pharmacy District Supervisor William Chun, RPH, PIC Conrad Bio, Pharmacy Development Manager Richard Martland, Attorney at Law Ronald Spolar, RPH, PIC Vernon Vierra, RPH Thomas Drew, Pharmacy Development Manager Joyce Matzen, RPH, PIC Ed Svihovec, Regional Pharmacy Manager Charles Ryll, RPH, PIC Roxanne Gueno, Pharmacy Development Manager Paul Vesely, RPH Bruce Painter, Director Professional Services Michael Sullinger, Attorney at Law

CALL TO ORDER

Chairperson Rich Mazzoni called the meeting of the Northern Compliance Committee to order at 10:00 a.m.

A. DISCIPLINARY APPEARANCES

1. Suban Poku CI 1998 17079
RPH 35834

Daniel P. Cashman
Director of Pharmacy

Folsom State Prison Pharmacy
Represa, CA
LCF 19590

The board canceled this appearance prior to this meeting.

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2 Tom Lee CI 1998 16803
RPH 38621, PIC

Florliza Agramon
RPH 47784

Walgreens
Daly City, CA
PHY 9280

Ronda Lowe, Pharmacy District Supervisor

Florliza Agramon, Tom Lee, and Walgreens were requested to appear at the Northern Compliance Committee Meeting as the result of an investigation that revealed that Walgreens dispensed Meridia 15mg on a new prescription written for Meridia 10mg. On a second fill of Meridia for the same patient RPH Agramon dispensed the medication with the incorrect dosage information. This error caused the patient to take two doses when the prescription was written for one dose per day. If proper consultation had been provided on one or both of these occasions, the prescription error could have been avoided. This prescription was also refilled at Walgreens on two separate occasions.

The following violations are charged to Walgreens and RPH Florzliza Agramon:

- Business and Professions Code Section 4301 - Unprofessional conduct.
- Business and Professions Code Section 4077 (a) – Dispensing dangerous drugs in an incorrectly labeled container.
- California Code of Regulations Section 1707.2 – Duty to consult.
- California Code of Regulations Section 1716 – Variation from a prescription.

The committee asked those present to explain the pharmacy's policy for checking in a new prescription.

Mr. Lee explained that the pharmacy's policy is that after the technician has typed the label and filled the prescription the pharmacist checks the label against the original prescription. The pharmacist then reviews the patient profile to ensure the appropriateness of the prescription being dispensed.

Ms. Agramon explained that she followed the pharmacy procedures. Ms. Agramon admitted that she made an error on the prescription in question, she failed to catch the incorrect dosage and the directions for use. Ms. Agramon added that if she had not been sure of the direction she would have called the physician for clairification.

The committee advised those present that the complainant stated that no patient consultation was provided on these prescriptions.

Mr. Lee responded that it is the goal of the pharmacy to achieve 100 percent consultation, however occasionally the cashier may forget to call the pharmacist for consultation. The prescriptions are marked with a bold “NEW”, but human error can still occur.

Ms. Agramon added that the pharmacy has a new procedure where all new prescriptions are stamped with a large red ink stamp, reading “See Pharmacist”.

Ms. Lowe explained that when she visits the pharmacies in her district, before she introduces herself to the pharmacy staff, she always waits outside the pharmacy area to observe for consultation.

The committee asked those present to identify the initials on the original prescription.

Mr. Lee identified the initials as those of the pharmacy technician on duty the day the prescription was filled.

The committee expressed concern as to why there were no initials of the pharmacist that verified that the prescription was filled correctly.

Mr. Lee responded that it is the pharmacy’s policy that the pharmacist initials the prescription at the time the prescription is verified.

M/S/C: Gubbins/Mazzoni

The committee accepted the appearance of Florliza Agramon, Tom Lee, and Walgreens; (a) the matter will be made a part of the record of Florliza Agramon, RPH 47784, and Walgreens, PHY 9280; (b) Florliza Agramon, RPH 47784 is cited and fined $1000, for failure to provide patient consultation as required; (c) a follow up inspection to take place within 120 day. No further action will be taken at this time.

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3. William Chun CI 1998 17301
RPH 30452, PIC

David Quon
RPH 37709

Rite Aid #6077
Sacramento, CA
PHY 42776

Conrad Bio, Pharmacy Development Manager
Richard Martland, Attorney at law

William Chun, David Quon, and Rite Aid #6077 were requested to appear at the Northern Compliance Committee Meeting as the result of an investigation that revealed that RPH Quon was responsible for a prescription error that allowed the wrong doctor's name to appear on prescription labels.

The following violations were substantiated for RPH Quon and Rite Aid #6077:

- Business and Professions Code section 4301 (o) – Unprofessional conduct.
- Business and Professions Code section 4076 (a) (4) – Requirements for labeling. The name of the prescriber and, if applicable, the nurse practitioner who functions pursuant to a standardized procedure described in section 2836.1, or protocol, or physician assistant who functions pursuant to section 3502.1.

Board President Rich Mazzoni recused himself from this case and left the room.

Board Member Donald Gubbins recused himself from this case and left the room.

David Quon failed to appear at this appearance, it appears that Mr. Quon is no longer working in the profession. No further action will be taken against Mr. Quon.

Mr. Chun stated that at the time of the incident the patient had just changed physicians. The new physician was called for authorization and refills. This was noted on the original prescription. When the prescription label was typed this changed was not captured.

Mr. Bio explained that the new policy is to make any changes in large bold print with a marker, not a ball point pen.

The committee expressed concern as to the number of prescriptions that are filled per day in the pharmacy, and the number of staff on duty.

Mr. Bio responded that on the day of the incident the pharmacy filled 309 prescriptions. The average is 1500 prescriptions per week. There are two pharmacists on duty each day, along with two pharmacy technicians and two clerks.

Mr. Bio explained that when ever an error is made in a pharmacy the Pharmacy Development Manager holds a meeting with the staff to determine how the error occurred and what steps need to be taken to prevent any further errors.

M/S/C: Shreve

The committee accepted the appearance of William Chun, and Rite Aid #6077; (a) the matter will be made a part of the record of William Chun, RPH 34052, David Quon, RPH 37709, and Rite Aid #6077, PHY 42776. No further action will be taken at this time.

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4. Ronald Spolar CI 1998 16369
RPH 25286, PIC

Vernon Vierra
RPH 22774

Rite Aid #6012
Modesto, CA
PHY 42751

Thomas Drew, Pharmacy Development Manager

Ronald Spolar, Vernon Vierra, and Rite Aid #6012 were requested to appear at the Northern Compliance Committee Meeting as the result of an investigation that revealed that it is unclear when the notes on refrigeration and storage were written on the hardcopy of the prescription for captopril. The instructions were written after a discussion with the prescribing physician, RPH Vierra did not label the prescription with the appropriate expiration date and did not consult/provide the proper storage instructions. The strength of the medication did not appear on the label.

The following violations are charged to Ronald Spolar, Vernon Vierra, and Rite Aid #6012:

- Business and Professions Code section 4301 (o) – Unprofessional conduct.
- Business and Professions Code section 4076 (a) (7) – Requirements for labeling. The strength of the drug or drugs dispensed.
- Business and Professions Code section 4076 (a) (9) – Requirements for labeling. The expiration date of the effectiveness of the drug dispensed.
- California Code of Regulations - 1707.2 – Duty to consult.

Board Member Donald Gubbins recused himself from this case and left the room.

Mr. Vierra stated that when he received the original prescription his first reaction was that he was not sure of the dispensing physician's instructions. Mr. Vierra's first action was to contact the physician. The physician's nurse informed Mr. Vierra of how to compound the prescription and to keep the medication refrigerated. The physician's nurse also advised Mr. Vierra that the medication could be kept up to 60 days if refrigerated.

Mr. Vierra added that he had the patient's mother sign a receipt acknowledging that she received patient consultation. Mr. Vierra stated that he is sure that he

consulted with the mother and that he told her to refrigerate the medication, he could not explain why there was not a refrigeration label on the container.

Mr. Vierra further explained that the pharmacy has purchased a Paddock Compounding Manual for the pharmacy, which lists compounding procedures and storage instructions.

Mr. Spolar stated that the pharmacy procedures for compounding have been revised. Currently the pharmacist will type the label, compound the medication and review all the double checks personally. The pharmacist will consult with the prescribing physician on the mixing instructions and any special expiration date the physician may want on the medication. The pharmacist will check the Facts and Comparisons for any and all procedures for stability problems. A consultant pharmacist is on staff in Modesto that can be contacted as a reference. Consult the Paddock Compounding Manual for compounding information. Also the pharmacy has ordered Paddock compounding solutions which are stable for such compounds.

Mr. Spolar stated that at the time the medication is dispensed to the patient or the patient's agent the person picking up the medication will be required to sign the receipt stating that he or she received patient consultation and understands the instructions for use of the medication.

The committee asked Mr. Vierra what he would do if he found a label error while performing patient consultation.

Mr. Vierra responded that if he caught a label error during consultation, he would re-label the prescription.

M/S/C: Mazzoni/Shreve

The committee accepted the appearance of Ronald Spolar, Vernon Vierra, and Rite Aid #6012; (a) the matter will be made a part of the record of Vernon Vierra, RPH 22774, and Rite Aid #6012, PHY 42751. No further action will be taken at this time.

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5. Susan Biggle CI 1999 17969
RPH 26930, PIC

Elbion Estrin
RPH 24130

Rite Aid #5842
Mammoth Lakes, CA
PHY 42568

This appearance was postponed prior to this meeting. This appearance will be rescheduled At a future Northern Compliance Committee meeting.

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6. Joyce Matzen CI 1999 17909
RPH 28790, PIC

Von's Pharmacy #185
Clovis, CA
PHY 32562

Ed Svihovec, Regional Pharmacy Manager

Joyce Matzen and Von's Pharmacy #185 were requested to appear at the Northern Compliance Committee Meeting as the result of an investigation that revealed that RPH Matzen dispensed Zoloft on a prescription written for Zocor, and dispensed Glucophage 500mg on a prescription written for Glucophage 850mg. RPH Matzen failed to provide patient consultation on a new prescription as required.

The following violations are charged to Joyce Matzen and Von's Pharmacy #185:

- Business and Professions Code Section 4301 - Unprofessional conduct.
- California Code of Regulations Section 1707.2 – Duty to consult.
- California Code of Regulations Section 1716 – Variation from a prescription.

Ms. Matzen stated that she was working 58 hours per week at the time of the incident. The pharmacy was short staffed due to illness as far as the pharmacists were concerned. Ms. Matzen had just come to the pharmacy as a staff pharmacist. The pharmacy has shortened their hours of operation, the pharmacy is now closed on Sundays as well.

The committee expressed concern with the seriousness and the number of errors made at the pharmacy.

Ms. Matzen explained that she did not fill the Zoloft prescription, there were no initials on the label. The day that the prescription was filled another pharmacist worked the morning shift with a technician and Ms. Matzen came on to work the afternoon shift with another technician. The Zoloft prescription was given to the patient during the shift change. Ms. Matzen believes that the prescription was filled by the morning technician and dispensed by the afternoon technician and never checked by a pharmacist. Ms. Matzen stated that the prescription did leave the pharmacy while she was at the pharmacy, so in that since she takes responsibility for the prescription.

The committee expressed concern as to what steps the pharmacy has taken to prevent further errors from occurring.

Ms. Matzen responded that the pharmacy staff has been increased to ease the workload on each individual. Also a new procedure has been initiated, where by all prescriptions filled by technicians are stored in a holding area until a pharmacist checks them. All the pharmacy staff is aware that no prescription can be removed from the holding area, except by a pharmacist. Ms. Matzen added that this had always been her normal procedure it is now followed by all staff.

Ms. Matzen stated that on the Glucophage dosage error, Ms. Matzen did not check the dosage because she knew the patient had taken 500 mg previously. Also Ms. Matzen did not offer patient consultation because the patient is an administrative nurse, and had told Ms. Matzen on several occasions.

M/S/C: Shreve/Gubbins

The committee accepted the appearance of Joyce Matzen and Von's Pharmacy #185; (a) the matter will be made a part of the record of Joyce Matzen, RPH 43055 and Von's Pharmacy #185, PHY 32562; (b) Joyce Matzen, RPH 43055, is cited and fined $500, for failure to provide patient consultation as required; (c) a follow up inspection to be performed within 180 days with direction towards organization and workflow; (d) Von's corporation is to draft a policy on standard workflow and to submit a copy to the board within 180 days. No further action will be taken at this time.

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7. Charles Ryll CI 1999 17774
RPH 32993, PIC

Wal-Mart Pharmacy #1575
Oroville, CA
PHY 36991

Roxanne Gueno, Pharmacy Development Manager
Paul Vesely, RPH
Bruce Painter, Director Professional Services
Michael Sullinger, Attorney at Law

Charles Ryll and Wal-Mart Pharmacy #1575 were requested to appear at the Northern Compliance Committee Meeting as the result of an investigation that revealed that PIC Ryll dispensed prescriptions written by a veterinarian prescribing outside their scope of practice. During the investigation additional violations of pharmacy law were determined.

On November 2, 1999 a violation notice was issued to Charles Ryll and Wal-Mart Pharmacy #1575 for violation of:

- Business and Professions Code section 4059.5 – Who may order dangerous drugs or devices, compliance with laws of all involved jurisdictions.
- Health and Safety Code section 11250 – Authorized retail sale by pharmacists to physicians, required order form.
- Business and Professions Code section 4059 (b) – This section shall not apply to the furnishing of any dangerous drug or dangerous device by a manufacturer, wholesaler or pharmacy to each other or to a physician, dentist, podiatrist, or veterinarian, acting within the scope of his or her practice or to a laboratory under sales and purchase records that correctly give the date, the names and addresses of the supplier and the buyer, the drug or device and its quantity.
- Business and Professions Code section 4301 (J) – Unprofessional conduct. The violation of any of the statutes of this state or of the United States regulating controlled substances and dangerous drugs.
- Business and Professions Code section 4081 – Records of dangerous drugs and devices kept open for inspection, maintenance of records and current inventory.
- Business and Professions Code section 4105 - Retaining records of dangerous drugs and devices on licensed premises, temporary removal, waivers, and access to electronically maintained records.
- Business and Professions Code section 4332 – Misdemeanor; failure or refusal to maintain or produce required drug or device records; willful production of false records.

Mr. Ryll stated that he felt that all of the prescriptions that he filled for the veterinarian were used for legitimate purposes within the scope of practice for a veterinarian. Mr. Ryll added that he did not feel that it was his place to judge a healthcare provider, or to require documentation as to substantiate what animal the medication was dispensed to.

The committee asked Mr. Ryll if a veterinarian could prescribe a medication for human use.

Mr. Ryll responded that a veterinarian could prescribe drugs for animals that are manufactured for human use, but can not prescribe for humans.

The committee asked Mr. Ryll to explain why he filled a prescription written by a veterinarian for Zyban, which is used for smoking cessation.

Mr. Ryll explained that he knew it would not be used for smoking cessation, but that it can be used just as Welbuterin can be used to treat depression. Mr. Ryll further explained that Phentermine while used in humans for dietary use is used in dogs for bladder control.

The committee expressed concern as to whether Mr. Ryll ever questioned the veterinarian with regard to the purpose of the drugs he prescribed.

Mr. Ryll responded he did not discuss it with the veterinarian.

M/S/C: Shreve/Mazzoni

The committee accepted the appearance of Charles Ryll, Wal-Mart Pharmacy #1575; (a) the matter will be made a part of the record of Charles Ryll, RPH 32993, and Wal-Mart Pharmacy #1575, PHY 36991; (b) A follow up inspection to be performed within 180 days at the pharmacy where Charles Ryll is currently employed. No further action will be taken at this time.

There being no additional discussion, the meeting was adjourned at 12:35 p.m.